Dr. Jacob Myers D.D.S., P.L.L.C.

PEDIATRIC DENTISTRY

2121 Abbot Road • East Lansing, Michigan 48823 • 517.337.0032
Fax: 517.337.8983 Email: yourchildsdds@gmail.com www.yourchildsdds.com

Child's Full Name: _____ **Nickname:** _____
Date of birth: ____/____/_____
Gender: ❑ **Male** ❑ **Female** **Height:** _____ **Weight:** _____
Date of last physical examination: _____
Name/address/phone of primary physician:
_____
Name/address/phone of medical specialists:
_____

Medical History:

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the space at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications with birth, prematurity, birth defects
❑ YES ❑ NO

Problems with physical growth or development
❑ YES ❑ NO

Sinusitis, chronic adenoid/tonsil infections
❑ YES ❑ NO

Sleep apnea/snoring, mouth breathing
❑ YES ❑ NO

HIV/AIDS
❑ YES ❑ NO

Congenital heart defect/disease, heart murmur
❑ YES ❑ NO

Irregular heart beat or high blood pressure
❑ YES ❑ NO

Asthma, reactive airway disease, wheezing
❑ YES ❑ NO

Cystic fibrosis
❑ YES ❑ NO

Frequent colds or coughs, or pneumonia
❑ YES ❑ NO

Frequent exposure to tobacco smoke
❑ YES ❑ NO

Acid reflux disease (GERD) or intestinal problems. ❑ YES ❑ NO

Lactose intolerance, food allergies, nutritional deficiencies or dietary restrictions
❑ YES ❑ NO

Sensory Disorder(s)
❑ YES ❑ NO

Autism/Asperger's/Autism spectrum disorder
❑ YES ❑ NO

Developmental disorders, learning problems/delays, intellectual disability
❑ YES ❑ NO

Attention deficit (ADD/ADHD)
❑ YES ❑ NO

Rash/hives, eczema or skin problems
❑ YES ❑ NO

Arthritis, or muscle/bone/joint problems
❑ YES ❑ NO

Cerebral palsy, Epilepsy, or seizures
❑ YES ❑ NO

Recurrent headaches/migraines, fainting or dizziness.
❑ YES ❑ NO

Bladder or kidney problems
❑ YES ❑ NO

Jaundice, hepatitis, or liver problems
❑ YES ❑ NO

Impaired vision, hearing, or speech
❑ YES ❑ NO

Behavioral, emotional, communication, or psychiatric problems/treatment
❑ YES ❑ NO

Abuse (physical, psychological, emotional, or sexual) or neglect
❑ YES ❑ NO

Diabetes, hyperglycemia, or hypoglycemia
❑ YES ❑ NO

Early onset puberty or hormonal problems
❑ YES ❑ NO

Thyroid or pituitary problems
❑ YES ❑ NO

Anemia (disease/trait), blood disorder.
❑ YES ❑ NO

Hemophilia, bruising, bleeding.
❑ YES ❑ NO

Transfusions or receiving blood products
❑ YES ❑ NO

Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant
❑YES ❑NO

Is there any other significant medical history **pertaining to this child or his/her family** that we should know? ❑ YES ❑ NO

If YES, Or more information is needed from above, please describe below:

_____

_____

Is your child up to date on immunizations against childhood diseases? _____

❑ YES ❑ NO

Is your child being treated by a physician at this time? Reason _____

❑ YES ❑ NO

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? _____

❑ YES ❑ NO

List name, dose, frequency & date started: _____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? _____

❑ YES ❑ NO

List date & describe: _____

Has your child ever had a reaction to or problem with an anesthetic? Describe _____

❑ YES ❑ NO

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____

❑ YES ❑ NO

Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____

❑ YES ❑ NO

Please list any other comments relating to your child's history:

_____

_____

_____

FAMILY REGISTRATION UPDATE:

Mother/Guardian's name: _____

Address: _____

Phone numbers: Home:_____ Cell:_____Work:_____

Dental Insurance: ❑ No ❑If yes: Employer: _____Insurance:_____

Contract number/subscriber ID: _____Group number:_____

Father/Guardian's name: _____

Address: (if other than above): _____

Phone numbers: Home:_____ Cell:_____Work:_____

Dental Insurance: ❑ No ❑If yes: Employer: _____Insurance:_____

Contract number/subscriber ID: _____Group number:_____

Any other dental insurance coverage? _____

Please provide your email address for appointment reminders and confirmation:

_____

_____ _____ _____

Signature of parent/guardian **Relationship to child** **Date**

Thanks for your cooperation,

Dr. Jacob Myers
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